



## Normal parents: Trans pregnancy and the production of reproducers

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### ABSTRACT

**Background:** Some trans people want to create families in a variety of ways that include pregnancy, but often face obstacles in doing so.

**Aims:** This paper explores how trans pregnancy is treated as exceptional and out of the ordinary by reproductive institutions.

**Methods:** Analysis of case studies demonstrates the ubiquity of institutional obstacles to trans pregnancy and how reproductive institutions unnecessarily render trans pregnancy exceptional.

**Results:** Reproductive institutions shape the kinds of people for whom achieving pregnancy is made easier, and often fail to imagine the possibility of trans parents. This failure of imagination is not rooted in biological fact, but rather in social logics that ought to be the site for transformations that expand access and shift provider attitudes.

**Discussion:** Trans parents are unexceptional in the sense that, even though they may experience relatively more concentrated forms of adversity, they share many reproductive capabilities and obstacles with cis parents. In light of that concentrated adversity and the epistemic insights it might generate, how might prospective trans parents engage with new reproductive technologies? How might these engagements render them moral pioneers called to make decisions about the sorts of people created using reproductive biotechnologies?

### KEYWORDS

Bioethics; reproductive technologies; transgender; trans pregnancy

### Introduction

Trans<sup>1</sup> pregnancy is unexceptional. It is not, however, treated that way. In popular culture and biomedical institutions, it is too often regarded as something out-of-the-ordinary and burdensome. But people with reproductive organs capable of gestation, trans and cis alike, can become pregnant and gestate progeny without biomedical intervention. Or rather, they can do so using only the biomedical intervention that is the norm (and as such, is the site of contestation and resistance) for births that involve western medical systems (Shaw, 2013). Trans pregnancy is also unexceptional because trans people who reproduce encounter a cavalcade of barriers that, while more likely to accrue to them, are by no means specific to them. In other words, when trans people experience discrimination and their access to care is limited or harmful to them, it is not because they pose extraordinary challenges to health systems. It is because health systems have

failed to recognize the ordinariness of gender identity diversity in people who reproduce.

That is not to say that in practice health systems and social prejudices regard trans people engaging in reproductive practices as unexceptional. In many cases, such systems and patterns of thought single out trans pregnancy as disruptive and difficult (Hoffkling et al., 2017). But systemic barriers are quotidian aspects of reproductive institutions: of the doctors, hospitals, insurance policies, ethicists, and other actors that together produce the conditions of possibility for contemporary western reproduction. These barriers are parts of systems that are working as designed to regulate who can and cannot be a parent. They are also needed sites for interventions that would center the well-being of trans people while engendering systemic changes to provider attitudes, access to care, and administrative designations of deservingness.

In what follows, I argue that trans people engaging in reproduction are unexceptional: their

reproductive practices generate needs that are contiguous with rather than distinct from other people engaged in reproduction. At the same time, trans pregnancy is *exceptionalized*: reproductive institutions constitute it as something difficult and unfamiliar, and in so doing reinforce barriers that need not exist. Pregnancy usually but does not always result in genetic relatedness, though surrogacy arrangements and gamete donation can inflect the way that genetics mediate relationships between parents and children. It can involve biotechnologies such as IVF (in vitro fertilization) and IUI (intrauterine insemination), but does not always require it. Social arrangements that make pregnancy possible tend to become visible when trans people pursue pregnancy, sometimes through assisted reproductive practices and sometimes through institutional roadblocks. Where does reproductive material come from and how did it get there? What financial and social mechanisms promoted or thwarted its possibility? What social and legal arrangements are at stake? Who gets considered to be a parent and how is their gender made legible (or not) in the process?

None of these questions are endemic to trans people or their pursuit of parenthood. But they become visible and urgent when trans people become parents, which makes it important to center trans people when establishing paradigms for answering them in just ways. Identifying as part of a broader category—trans man, cis lesbian, nonbinary parent—says something about some features that a person may have, but these category memberships offer mere gestures toward facets of identity. These categories are important because those within them share features, but those features are general and full of exceptions. Trans men who wish to become pregnant probably use he/him pronouns, they probably have encountered healthcare discrimination (Grant et al., 2011); they also might not. They might have undertaken endocrinal interventions, which would need to be paused; they also might not. They might have undergone chest reconstruction, the clinical importance of which might be overdetermined by care teams. They might deploy assisted reproductive technologies, or nothing more than a willing partner. The question of

where gametes come from might be more obvious to ask of trans men than of cis/het prospective parents, in that trans parentage might also confront cis- and heteronormative presumptions about gendered partnerships. But where trans pregnancy makes the need to interrogate assumptions about partner status, gender identity, pronoun use, and histories of poor treatment by healthcare providers in the past more visible, none of these features are exclusive to trans people.

This is a substantially different assertion than saying that trans men (for example) ought to be thought of like or as cis women. Instead, this paper takes pregnancy as its object and argues that gender identity need not determine its course. The resource needs that pregnancy creates are not substantially different between gestators<sup>2</sup> of different gender identities, though the effects of systemically conferred advantages and disadvantages may be experienced disparately. I argue that gender identity is overdetermined within discourses about trans pregnancy, and that regarding trans identity as unexceptional—not as unimportant, but rather as a difference that does not produce deviation and instead grounds the same claims as cis reproducers—is fruitful. The stakes of this shift, of moving from seeing trans parents as requiring exceptional treatment, to centering them and seeing them as unexceptional, reside in institutions: the places and systems that facilitate reproduction. With a call to understand that trans reproduction is unexceptional, I do not aim to valorize normativity. Rather, I intend to highlight how trans pregnancy does not by virtue of occurring repudiate reproductive norms; and I argue that institutions that treat it as abnormal and exceptional err in doing so.

Reproductive institutions ought to imagine that all of their clients could be trans, that they might not know the gender identities of their clients, and that a moral imperative nevertheless exists to provide competent and effective care to all they serve. This call to reframe imagination draws upon thinking about social and institutional imaginaries: the norms and patterns of thought that come to be embedded in institutional policies and practices (McNeil et al., 2017). Institutions need to reframe their imaginaries in order to invite and make space for a broad array

of gender identities and expressions, some of which will be occasioned by trans people and others by the broad array of gender presentations manifested by cis people.

Doing so would force attention and drive systemic change to the social arrangements and roadblocks that create disadvantage for trans reproducers, such as trauma caused by discriminatory healthcare providers, misgendering health records, assumptions about desire or ability to reproduce, and inadequate access to reproductive services such as gamete preservation, abortion services, and assisted reproductive technologies (Smith, 2016). Policies and practices within institutions make reproduction more accessible for some and more difficult for others. Shifting institutional imaginations of who their subjects are makes visible the ways that trans reproducers are often foreclosed from reproduction, even within the biomedical institutions that purport to make reproduction possible.

In what follows, I explore how trans pregnancy is made difficult in ways that are similar to the ways that cis pregnancy is made bureaucratically difficult—through insurance coverage for infertility, determinations of what constitutes “essential” healthcare during a pandemic, and legal determination of parental title. Through this difficulty, I argue that trans pregnancy is unexceptional: it is not without complication, but that complication is the norm. Key, however, is that much of that complication is manufactured, which renders it an appropriate site for interventions aiming for more just treatment. Having established many aspects of this difficulty as both unexceptional and socially constructed, I then offer an account of how reproductive institutions single out trans parents for difficulty in ways that also do not need to be the case. I focus on the way they constitute objects of ethical inquiry. Professional societies affirming that trans parents ought not be discriminated against simultaneously perform important ethical work and evince a broader culture that demands such a pushback. In a different mode, bioethical scholarship that explores the ethics of fertility preservation is often rooted in normative presumptions about the importance of biological reproduction and the harms of its abrogation, inventing ethical uncertainty that

translates into reduced access. From this account of the normalness, and then the constructed exceptionality, of trans pregnancy, I conclude by asking: Is there something about trans pregnancy that might render its practitioners moral pioneers? As reproductive biotechnologies proliferate in the world and in imaginations of the future, how might articulating that trans people are both quotidian reproducers and in positions to make radical interventions into family creation reshape reproductive practices in more just ways?

### Normal parents

Trans people who give birth to children share many experiences and needs with cis women who do so. They share a social milieu and are obligate participants in reproductive institutions structured by norms and values that make legible and possible the reproduction of some kinds of people and obscure and difficult for others. The medical system creates and enforces notions of “correct” gender for all who pass through it. This happens in countless ways: by misgendering people via billing codes (Bidel, 2019) and prescriptive language (Bouman et al., 2017); by denying or forcibly providing gender-related medical interventions (Guthrie, 2018; Kattari et al., 2020); by presuming that queer adolescents won’t experience unintended pregnancies (Veale et al., 2016); and by marking poor, Black, incarcerated, trans, and other socially-disadvantaged people as unworthy parents (Roberts, 1997). These are patterns of disciplining that concentrate on trans people but are nevertheless parts of a broader exercise of power to which other potential reproducers are subject as well. There exists a tendency to both exceptionalize and render invisible trans reproduction, through sensationalized coverage of “pregnant men” (Pearce & White, 2019) and the reification of pregnancy as something that pertains to “women.” Similarly, there is a tendency to regard trans women as a case example for complicated and limited interventions like uterus transplantation, while simultaneously leaving understudied more broadly and immediately applicable questions about, for example, restoration of spermatogenesis after taking estrogen (Hembree et al., 2017).

While there are real and important identity-based differences between people with different gender identities (to say nothing of the real and important differences between people within those categories as well), I argue that from the perspective of the needs that such pregnant people (and people with the potential to become pregnant) have, and the claims that those needs justify, it is generative to consider them as part of a group with shared interests. We should work not to exceptionalize trans pregnancy, and to instead construct systems that attend capaciously to the needs associated with pregnancy as a broad category of experiences for many types of people, cis as well as trans.

Gender identity, as such, does not determine desire or ability to conceive or bear children. Rather, medical, legal, social, biological, and identity factors interweave to make reproduction easier for some people and more difficult for others in what Kimberly Mutcherson (2017) and others term “reproductive hierarchies.” This can happen in ways obviously linked to pregnancy and the process of conception: Where do the gametes come from? What legal mechanisms are necessary to create legible family arrangements between parents, partners, and children? But it also happens in ways less overtly about pregnancy that nevertheless express values about who constitutes a rightful parent or suitable gestator. These processes take many forms and what follows is by no means exhaustive. Rather, policies governing who has access to reproductive medicine and under what conditions and who is designated a legal “mother” illustrate ways that people with any number of interlocking identities are subjected to forms of reproductive control.

A 2016 case in the US state of New Jersey concerns insurance coverage of infertility treatment for coupled cis women. It illustrates how institutions construct policies rooted in notions of deservingness that fail to imagine the possibility of categories of need outside of their demarcations of legitimacy. New Jersey’s state plan required that infertility be proven—or in the case of the plaintiffs, produced—via a period of 6 months of “unprotected intercourse”<sup>3</sup> if a woman is over 35, or 2 years if under (Mutcherson, 2017). The women sued because

there was no way for them to enter into the pathways by which fertility assistance is available. Infertility treatment was something covered by their insurance, but their insurance failed to imagine that they were the sort of people that it covered—a paradigm of exclusion that affects trans people as well.

The New Jersey requirements construct a definition of medical infertility that can then be used to adjudicate whether infertility treatments are necessary. This way of denoting infertility draws upon purported facts of the body: supposedly objective, universal markers that make it possible to assign a biological origin to the problem of infertility. In turn, medical infertility becomes the sort of thing that is within the purview of the medical system to fix. A definition of infertility grounded in a biological logic, however, elides the social factors that may effect the same outcome via different means. Where medical infertility arises as a result of any number of conditions and is often only apparent after a period of sex that could lead to pregnancy but does not, social infertility occurs due to factors exogenous to the physical body. These include career paths that demand reproductive delays, insufficient access to reproductive healthcare, and not having a partner or having a partner who cannot or will not provide gametes (Sussman, 2019). New Jersey’s health plan already naturalized a set of values about the importance or essentialness of procreation. By covering assisted reproductive technologies in the case of infertility when many plans still do not, it makes clear that something about reproduction is important and worth treating as essential to the production of health and wellbeing, rather than optional or luxury.

But the language of the construction of medical infertility, as the thing that exists and the thing that counts within policy, also makes clear that some kinds of reproduction are more correct than others. Policy needs not explicitly state the populations it aims to manage and call into being in order to do so by making some things easy, others hard, and still others impossible. There is an implicit valorization of “natural” reproduction at play—where “natural” is tethered to heterosexuality and the fictional paring of normalness and unassistedness. The kind of reproductive

assistance that the New Jersey policy covers corrects for errors or deficiencies in the working of supposedly unassisted reproduction. It does not imagine that pregnancy might happen by design in ways that, without anything going wrong, still require assistance. In so failing, this policy establishes a relationship of deservingness between individuals and reproductive institutions.

Reproduction that would happen according to unassisted norms, but fails through biological accident, is deserving. Reproduction that needs assistance from the outset is not. In tethering deservingness to the production of infertility by medical means, that which comes about socially—by having a partner who can't or won't offer the requisite gametes, being single, or being a trans person whose reproductive capacities have changed during transition—is marked as undeserving of intervention, and imagined out of subjectivity. The takeaway from this case is not that insurance plans cover some things and not others; that is a banal reality of all insurance plans. Rather, seeing what is included and excluded is a way of seeing the process by which such plans imagine and then enact values about which kinds of subjects are deserving, which ways of being ought to be supported, and which ought not.

Social processes managing who gets to be a parent (and what kind) also take legal forms. In 2018, a trans man gave birth to a child in the UK. After Freddy McConnell was listed as his child's mother when registering the birth (despite his identity documentation indicating male gender), he sued to be considered the child's legal father and lost. By denying his request, the UK affirmed that anyone who gives birth is legally a "mother" regardless of legal gender identity (Magra, 2020). This decision legally instantiates misgendering, affirming a precedent that will bind future trans parents. It was widely viewed as a disappointment by transgender advocates as it reifies a biological logic of relatedness that does not account for the import of the experiences and identities of trans parents. It is another way that transgender identity is allowed legibility as an individual phenomenon, but treated as an impediment or impossibility in reproductive contexts.

As Pearce et al. (2019) note, however, this decision also does the work of transforming and

rendering newly durable the category of mother. It codifies as legal fact that the person who births a child is its mother: it is not the gender of the gestator but rather the act of birthing that determines the legally-correct parental title. In so doing, it decouples "mother" from "female," attaching it instead to reproductive role. It signals gestational relationship rather than gender. This logic is not limited to trans parents. In UK surrogacy arrangements, the surrogate is legally considered to be the child's mother, regardless of who the intended parents are and even if those parents provided the gametes requisite for its reproduction. Intended parents can become legal parents by parental order or adoption starting six weeks after birth (*Surrogacy*, n.d.). In both the case of trans men carrying children and surrogacy arrangements, the category of "mother" is a legal arrangement, decoupled from gender, intended parentage, and biological origins. Legal contestation has produced outcomes that instrumentalize "motherhood" in the interests of what the decision in McConnell's case deemed "a clear and coherent scheme of registration of births" (*McConnell v Registrar General*, 2020). The state therefore categorizes people as "mothers" in ways that maintain the presumptive fact of "mothers" bearing new life, irrespective of gender identity.

In the United States in 2020, determinations about what constitutes essential and non-essential kinds of reproduction were made visible as new public health measures intended to limit exposure and reallocate resources to pandemic response were implemented in response to the novel coronavirus. Along with countless other procedures determined to be elective or non-essential, the American Society for Reproductive Medicine recommended that reproductive interventions such as IVF, IUI, and egg freezing (but not prenatal care) be paused indefinitely, outside of a set of conditions that would render those interventions emergent (Caron, 2020). As of May 2020, there was not guidance that people should refrain from getting pregnant *sans* biomedical intervention. Consequently, those who do not require biomedical assistance in getting pregnant are privileged, despite generating needs that the healthcare system will need to attend to. This constitutes a valorization of the idea of freedom from assistance,



by making more easily possible the reproduction of those who can achieve pregnancy absent biomedical processes.

Such judgements about what constitutes essential and inessential services are important places for understanding social valuation. It is true that the United States, like most of the world in spring 2020, entered into a state of national emergency. Accordingly, people across socioeconomic strata and walks of life responded to the call to make sacrifices; some with life or death consequences, others with incalculable bearing on emotional and social well-being. It might indeed be the case that this arrangement, in which some pregnancies remain possible while others are foreclosed, was the necessary order of things during the pandemic (Thomas & Caplan, 2020). But crisis is used to condition other possibilities for reproductive futurity. While the pandemic continued, a whistleblower complaint provided evidence that women in immigrant detention centers in the US were simultaneously denied needed reproductive and COVID-related care, and forced to undergo unneeded hysterectomies (Project South, 2020). Here the crises of immigrant detention and pandemic authorize in ways starkly unjust the provision and withholding of biomedical technologies for reproductive control.

In each of these examples, legal and biomedical processes—which are social arrangements given the heft of law, the durability of policy, and expression through biomedicine—mediate who gets to be a parent. In each, trans people are implicated, and gender identity matters, but we can see broader processes disciplining bodies into being acceptable reproducers that extend beyond gender identity and conscript those people who live outside of legible norms into either changing or being excluded. Trans gestators are unexceptional because the impediments that they face are not exceptional to them; they are subject to systemic failures, oversights, and systems by which features of good reproduction and good reproducers are created and managed.

Trans reproduction makes clear but certainly does not invent what many who think about reproduction and justice have always known: that all reproduction is assisted and that there is not family creation outside of networks of support

and interdependency (Emre, 2018). For those that use assisted reproductive technologies, this is self-evident. But it is important to see how even that which is valorized as “natural”—the kinds of pregnancies that experience fewer inhibitions during the COVID-19 lockdown, the kinds that occur as the result of cis/het sex, the kinds that don’t explicitly apply for welfare benefits—are nevertheless inextricably intertwined with systems of care and support and assistance (Darnovsky, 2018). This is the case if there are no complications, if prenatal care is routine and pre-birth preparation looks like family and friends throwing showers and helping stockpile diapers. It is also the case if there is testing, illness, intervention, bed rest, or any of the myriad things that can go “wrong” in the course of gestation. Interruption is normal; assistance is normal. There is no such thing as reproduction without intervention; to aspire to that is to under-resource the very conditions of possibility for reproduction.

### Exceptionalizing institutions

Reproductive institutions do, however, exceptionalize trans reproduction. “Trans broken arm syndrome” is a phenomenon coined to describe the ways that healthcare professionals connect any health concern (broken arms are the eponymous stand-in for all possible ailments unrelated to gender identity and transition) to their patients’ trans identity (Knutson et al., 2016; Payton, 2015). This phenomenon has been widely documented in the popular and scholarly literature as it relates to the kinds of emergent concerns that bring people to the doctor’s office. It often results in mis- or under-treatment by physicians who claim not to know how to treat trans people or who worry that standard therapies will work differently in the presence of hormone replacement. It is less explicitly well documented as it pertains to pregnancy, though it can be found by turning to the framing of professional society guidance on trans pregnancy, such as that released by the American Society for Reproductive Medicine’s (ASRM) Ethics Committee opinion on “access to fertility services by transgender persons” (Ethics Committee of the ASRM, 2015). In it, ASRM

opens by rightly asserting that “Transgender persons have the same interests as other persons in having children and in accessing fertility services for fertility preservation and reproduction,” and goes on to note that “programs should treat all requests for assisted reproduction without regard to gender identity status.”

It is the second line of the document that does the work of exceptionalizing—signaling the institutional presumptions and histories against which ethics guidance abuts. It reads: “While current data are sparse, they do not support restricting access by transgender persons to reproductive technologies and do not support concerns that children are harmed from being raised by transgender parents” (Ethics Committee of the ASRM, 2015). It is not the guidance of the line that is of interest here. Indeed, there is a moral call as well as one increasingly supported by peer-reviewed evidence and the testimony of trans people that the reproductive liberty of trans people must not be restricted. Rather, it is the fact that such a line is necessary that is notable.

This call is juxtaposed with firm statements that trans people ought to be treated just like cis people. Stating that there is not evidentiary support for restricting access to reproductive technologies is therefore a counterargument; it means that people, somewhere, are making an argument for restricting access to reproductive care strongly enough that it merits an institutional response. Trans people, then, in the eyes of the ASRM, may have the same interests as everyone else, but they are not just like everyone else. There are ethical questions about whether they ought to be permitted access that have been asked prior to this guidance and demand that the professional society marshal its institutional voice in order to put them to rest. The ASRM does not itself do the work of exceptionalizing, but it makes clear that others have done so in impactful ways. This is not to say that the ASRM erred in crafting its guidance—indeed, it is key in setting and, in this case resetting, reproductive norms. Their policy-making has real impact on those providers who turn to it. But in demarcating the phenomenon of sameness, they expose underlying presumptions of difference.

Nevertheless, the tension between “trans people have the same interests as cis people” and “trans people’s reproduction should not be limited” is important because it signals the very real legacy of reproductive discrimination that has long structured the pregnancy experiences of not only trans people, but virtually anyone who was not deemed to be an ideal (e.g., cis, healthy, wealthy enough, age appropriate, racially appropriate, weight appropriate) reproductive subject in the eyes of reproductive medicine and the state. Both trans and cis people are subject to normative expectations that they reproduce, if biologically able, even while contradictory social supports disenfranchise those not deemed “good” reproducers (Riggs & Bartholomaeus, 2020). Reacting to a legacy of reproductive infrastructure that renders reproduction both required (for some) and foreclosed (for others) requires explicit policy guidance to course correct. But in so doing, it reinforces that trans pregnancy is something that needs to be treated as precarious and that requires evidence to support, rather than proceeding as a default possibility.

The ASRM guidance offers an example whereby in reacting against an unsavory option, that option is granted the legitimacy of being the starting point against which change must be enacted. By invoking the mounting body of evidence in support of it, trans reproduction becomes the change to the status quo, the thing that providers must be trained to accept, rather than a baseline presumption demanded of them. We know from mounting collections of data that providers deny all sorts of care to trans people, so this change in status quo is needed (e.g. Kattari et al., 2020). Nevertheless, the ASRM guidance offers one illustration of how exceptionalism is structurally produced. Trans reproduction that encounters institutional barriers does not do so because of natural facts. Rather, these barriers arise out of social and institutional processes, policies, and practices and prejudicial patterns of thinking.

One prejudicial pattern of thinking gets naturalized in the way that ethicists constitute their objects of inquiry. Where advocacy positions take as their starting point the fact of a problem and offer concrete steps for redress, ethical analysis of

a problem treats the solutions as questions: What ought we do? What is the right question to ask in order to produce a just answer? This is needed work, but the act of constituting an ethical problem is not, itself, without morally and ethically significant ramifications. This is particularly the case in considerations of the ethics of trans pregnancy. There are ethical questions adjacent to trans pregnancy that offer, as bioethicists often frame their sites of inquiry, places for “reasonable people to disagree.” These do not take up the question of whether trans people ought to be able to reproduce (they should), but rather dimensions of the ways in which they can. How ought we balance the concerns of surrogates with those of intended parents? What, if any, is the right kind of genetic testing to build into in vitro fertilization? Should gamete donors be compensated?

Fertility preservation, I argue, is a different sort of case. Articles discussing the ethics of trans reproduction often take the question of fertility preservation as an object of inquiry and contention (Chen & Simons, 2018; Hudson et al., 2018; Murphy, 2012). How these questions are formulated matters. Trans pregnancy, like all pregnancy, happens within a system of interconnected people and institutions. The people and institutions that many need to achieve pregnancy while trans, such as fertility specialists, supportive families and partners, and safe housing with room to grow, are difficult to access for many trans people. Asking whether or not trans people ought to be able to become parents is not the sort of question whose answers generate access to these needed forms of assistance. Future fertility is of particular concern to trans people because for many (but by no means all), reproductive capabilities shift or attenuate during the process of medical transition. Best practices from the perspectives of reproductive medical associations, trans health organizations, and interviews with and testimonies by trans people, all suggest that the offer of fertility preservation ought to be a constituent part of medical transition (Fiorilli, 2019; Morong & Hinz, 2020; Nixon, 2013). The effectuation of this best practice is, then, something that requires advocacy and systemic change. Health systems and the people within them need to create the conditions of possibility for trans people to be given meaningful options to preserve their fertility, should they desire it.

Constituting fertility preservation as an ethical question is a different sort of problem when the ethical dimensions are located not at the level of the health system and access to it, but at the level of the individual. Questions of the ethics of fertility preservation, particularly for trans youth, presume an orientation toward the desire for children. Procreation is the default norm and interventions that might abrogate its possibility are treated as sites of potential loss, as a set of potential harms that require mitigation. From that normative framing, the ethical question becomes: Should youth be allowed to undergo permanent transition-related interventions that might affect their reproductive capabilities if they do not also undertake fertility preservation measures? This question is grounded in multiple uncertainties: about the long-term effects of hormones on fertility, about potential changes to reproductive desires, and about the evidence base for transition-related interventions (Shuster, 2016). Ethical frameworks that regard doing nothing as the default and transition as the site of potential harm elide how not transitioning can itself be the site of trauma.

The answer to questions of whether transition ought to be permitted, or permitted in the absence of fertility preservation measures, might (in light of the present analysis) be: Yes, of course! But the process of asking such questions, of deciding what are the right questions to ask, and which are the facts and norms that ought to be presumed as starting points, sediments ways of thinking and shifts analysis away from the systemic—institutional barriers and prejudicial patterns of thinking—to questions of individual permissibility. In so doing, a set of defaults about the presumptive good and desirability of reproductive capability are reified rather than those perturbations that might effectuate a broader set of systemic changes and create conditions of possibility for meaningful choices to reproduce even (and particularly) for transitioning youth.

Having argued that trans reproducers are just like everyone else, only more so, I offer that transness in reproduction is nevertheless quite important. By noticing how trans reproducers are at once unexceptional and subject to heightened precarity via processes that exceptionalize them,



we can see how retooling reproductive practices and institutions to center them, to eliminate friction between their family creation aims and their effectuation, offers tangible and non-instrumentalizing benefit. It also offers a model for systemic shifts toward more just reproductive institutions, policies, and practices for everyone. Trans peoples' needs should be centered. We can see this as necessary by asking: What norms would be reimagined if the needs of trans people were met? What ethical questions would be at stake? What would go unchallenged? For whom would possibilities arise?

### **Queers, moral pioneers?**

Trans pregnancy is also unexceptional in that it is not inherently the site of radical transformation. It can be made exceptional and required to be radical by the social conditions of its occurrence and the hostility of a too-often-transphobic world. But trans people, by virtue of existing and building families, do not overthrow established norms about reproduction. They do not automatically destabilize the family. Their mere existence does not queer norms of kinship. This is productively and importantly banal; a banality that, foreclosed from many, is the inheritance for some of generations of activism, subversion, and struggle for acceptance. The option of invisibility is a classed and raced privilege. Nevertheless, it is possible for some trans people to desire and deserve social arrangements that enforce rather than repudiate the nuclear family, that contain genetically related children, and that are recognized by the state. At the same time, the precarity that often attends trans life raises, for many people, the stakes of these demands for social legibility rather than for their overthrow. This is not to say that transness is not an important site for radical change and more expansive ways of thinking, nor is it to discount the effects that social marginalization and violence have on people and the way they interact with the world. But the mere fact of transness does not itself mean that the terms of social order are overthrown.

But this doesn't have to be the case. New technologies generate new moments for moral imagination and trans people are well situated to

seize them. It might not be the case that trans people are just like everyone else. While their needs, I argue, ought to be seen as similar to cis peoples', trans people also experience family creation, discrimination, kinship, joy, and much more on the axes of their gender identities and sexualities in ways that can be (but are not necessarily) distinctly queer. Queerness lives in the places where assistedness is visible, where the right or ability to create a family has been contested, where life outside of normative expectations generates epistemic insight and particular attention to marginalization. What counts as "queer" is the subject of much contestation; here, I use it expansively to connote repudiation of dominant norms that live within gender and sexuality. For many, trans pregnancy involves the use of reproductive biotechnologies, technologies that by their nature shape the kinds of people whose birth is possible. These technologies offer moments of heightened control and more inroads for making decisions, for which I hope that epistemic insight born of queerness—ways of thinking forged in the joys and adversities of transness—might orient decisionmakers toward justice.

Reproductive biotechnologies such as IVF require decisions about what kinds of people are to come into being, or more specifically, what sorts of people are selected out. These evaluations are largely naturalized under the auspices of the creation of "healthy" progeny with the greatest chance of being carried to term and delivered without complication. Heritable genetic diseases are screened out, but the lines between that which would be incompatible with life, that which eliminates disability, and that which reproduces imagined norms about ideal human forms are contentious and blurred.

Rayna Rapp's notion of "moral pioneers" suggests a productive framing for the interactions of queer and trans people with reproductive biotechnologies. Her work focuses on how early adopters of amniocentesis, which tests for genetic variations in utero, were confronted with decisions to test or not, and how people acted on the information that those tests produced. She found that people were called to grapple with their newfound ability and consequent duty to make choices about the kind of progeny that they

would call into the world. No longer could the fiction of the “natural” be allowed to substitute for ethical judgment about the choices that shape reproduction. Amniocentesis rendered those choices explicit and, under her analysis, transformed the people making them into moral pioneers (Rapp, 2000).

New reproductive biotechnologies that include gene editing techniques such as CRISPR Cas-9 (NIH, 2020) promise to offer new and more precise control over what kinds of traits are passed onto offspring. They offer not only prenatal genetic diagnosis, but also the ability to change embryos, creating new traits, immunities, and features. This has already happened in a pair of Chinese twins in which gene editing conferred (expected) immunity to HIV (Hurlbut, 2020). Where Rapp saw pregnant women as moral pioneers confronting a new set of reproductive choices mediated by the advent of amniocentesis, I argue that those for whom these new genetic technologies will become possibilities will also become moral pioneers. They are in a position to see how decisions about what kinds of people, using biotechnology, are allowed to come into being, and in turn decide whether to reject or accept the norms who ought to come into being that reproductive medicine structurally encourages. The kinds of reconfiguration of norms, legacies of care and kinship, and attention to difference that queerness can but does not necessarily potentiate might lend epistemic insight to this new crop of moral pioneers. Individuals’ epistemic insight is, of course, not enough: it must be taken on board by the reproductive institutions that facilitate reproduction and provide (and withhold) material support that allows it to happen. Nevertheless I hope that a queer moral imagination about reproduction is possible: one that takes a capacious view of the kinds of difference that ought to be imagined and claimed, and that sees reproductive choices as meaningful and not prescriptive of heteropatriarchal norms.

## Notes

1. In this paper, I take “trans” as an expansive and elastic category; encompassing anyone who is not cis (Enke, 2012).

2. I use “gestator” throughout when discussing pregnant people to focus analysis on the labor of pregnancy itself, and the way that can be undertaken by people (certainly not only cis women) with a wide variety of gender identities who nevertheless have needs, interests, abilities, and barriers in common.
3. Hetero- and cis-sexism is plain in the silences of “unprotected intercourse.” Sex that involves the insertion of penis into vagina is what is meant but unstated in this codification of the sort of sex that justifies the future need for assisted reproductive technologies, explicitly leaving out other bodily configurations, even those that could be considered “intercourse.”

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## Ethics

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